

(3) The information was provided in a manner that was reasonably designed to effect informed agreement and met the requirements of paragraphs (g) and (h) of this section.

(g) *Enrollment information.* Enrollment information was provided by one of the following methods or a similar method:

(1) Presentation of an enrollment card or other document attesting to enrollment.

(2) Notice of enrollment from HCFA, a Medicare intermediary or carrier, or the M+C organization itself.

(h) *Information on payment terms and conditions.* Information on payment terms and conditions was made available through either of the following methods:

(1) The M+C organization used postal service, electronic mail, FAX, or telephone to communicate the information to one of the following:

(i) The provider.

(ii) The employer or billing agent of the provider.

(iii) A partnership of which the provider is a member.

(iv) Any party to which the provider makes assignment or reassigns benefits.

(2) The M+C organization has in effect a procedure under which—

(i) Any provider furnishing services to an enrollee in an M+C private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, can receive instructions on how to request the payment information;

(ii) The organization responds to the request before the entity furnishes the service; and

(iii) The information the organization provides includes the following:

(A) Billing procedures.

(B) The amount the organization will pay towards the service.

(C) The amount the provider is permitted to collect from the enrollee.

(D) The information described in § 422.202(a)(1).

(3) Announcements in newspapers, journals, or magazines or on radio or television are not considered communication of the terms and conditions of payment.

(i) *Provider credentialing requirements.* Contracts with providers must provide that, in order to be paid to provide services to plan enrollees, providers must meet the requirements specified in § 422.204(a)(1) and (a)(1)(iii).

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000]

§ 422.220 Exclusion of services furnished under a private contract.

An M+C organization may not pay, directly or indirectly, on any basis, for services (other than emergency or urgently needed services as defined in § 422.2) furnished to a Medicare enrollee by a physician (as defined in section 1861(r)(1) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under section 1802(b) of the Act with the beneficiaries. An M+C organization must pay for emergency or urgently needed services furnished by a physician or practitioner who has not signed a private contract with the beneficiary.

Subpart F—Payments to Medicare+Choice Organizations

SOURCE: 63 FR 35090, June 26, 1998, unless otherwise noted.

§ 422.249 Terminology.

In this subpart—

(a) The terms “per capita rate” and “capitation rate” (see § 422.252) are used interchangeably; and

(b) In the term “area-specific,” “area” refers to any of the payment areas described in § 422.250(c).

§ 422.250 General provisions.

(a) *Monthly payments—(1) General rule.* Except as provided in paragraphs (a)(2) or (f) of this section, HCFA makes advance monthly payments equal to $\frac{1}{12}$ th of the annual M+C capitation rate for the payment area described in paragraph (c) of this section adjusted for such demographic risk factors as an individual's age, disability status, sex, institutional status, and other such factors as it determines to